Replaces VHA Directive 97-053

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 98-038

August 24, 1998

MEDICAL CARE FY 1999 NETWORK ALLOCATION

1. PURPOSE: This Veterans Health Administration (VHA) directive provides policy and procedures for the Fiscal Year (FY) 1999 Network Allocations and their use. The President's budget is the basis for the allocation of funds to Veterans Integrated Service Networks (VISNs). Future adjustments, depending on Congressional action, may be required.

2. BACKGROUND: The vast majority of the Network Allocations are prepared using a prospective payment funding system called the Veterans Equitable Resource Allocation (VERA) system. VERA was implemented in April, 1997, and will continue to be used for the FY 1999 Network Allocation.

3. POLICY: This directive describes the process concerning the allocation of funding to Networks and provides specific instructions pertaining to programs which have unique funding requirements.

4. ACTION

a. **Format**

(1) The FY 1999 Network Allocation will be prepared by the VHA Office of Finance (172). Data to populate the Network Allocation will be provided as follows:

(a) Section I - Allocation Resource Center, and

(b) Section II - Chief Network Officer and/or Network Directors.

(2) Network Allocations will be provided at the VISN level. Each VISN will establish an initial contingency reserve of at least 2.0 percent of its General Purpose allocation. Initial fiscal year Network Allocations to facilities are at the discretion of the Networks and will be developed in accordance with VHA Directive 97-054, Network Resource Allocation Principles. After approval by Headquarters, each VISN will provide a quarterly distribution of their facilities budgets to the Resource Allocation and Execution Office (172) for input into the Automated Allotment Control System (AACS).

b. **Instructions**. Attachment A provides Network Allocation line item explanations and general guidelines for their application. Attachment B provides a list of commonly used terms and their definitions.

5. REFERENCES

a. VHA Supplement to MP-4, Part VII.

THIS VHA DIRECTIVE EXPIRES SEPTEMBER 30, 1999

b. Office of Management and Budget (OMB) Circular A-34.

6. FOLLOW-UP RESPONSIBILITY: The VHA Chief Financial Officer (17) is responsible for the contents of this directive.

7. RESCISSION: VHA Directive 97-053 is rescinded. This Directive expires September 30, 1999.

S/ Thomas Garthwaite, M.D. for
Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

Attachments

DISTRIBUTION: CO: E-mailed 8/27/98
FLD: VISN, MA, DO, OC, OCRO and 200-FAX 8/27/98
EX: Boxes 104, 88, 63, 60, 54, 52, 47 and 44 - FAX 8/27/98

ATTACHMENT A

FY 1999 NETWORK ALLOCATION EXPLANATIONS AND GUIDELINES

1. **Fiscal Year (FY) 1999 Veterans Equitable Resource Allocation**

a. Approximately 86.5 percent of the FY 1999 Medical Care appropriation will be distributed to the Networks in Section 1 of the FY 1999 Network Allocation using the Veterans Equitable Resource Allocation (VERA) system.

b. Funds will be allocated through VERA's seven model components: Single Visits, Basic Care, Complex Care, Research Support, Education Support, Equipment, and Non-recurring Maintenance. When General Purpose funds are allocated (i.e. Single Visits, Basic, Complex Care, Research Support, and Education Support), no Network will experience a reduction below FY 1998 of more than 5 percent.

c. The veteran count that is used for the allocations is adjusted to reflect the location of their care. Each veteran's care is pro-rated among the Veterans Integrated Service Networks (VISNs) which are expected to participate in their care. This pro-ration technique is referred to as Pro-Rated Persons (PRPs).

d. The pool of resources that will be allocated by VERA will consist of resources for all activities allocated in the FY 1998 Network Allocation Section I, Section II, and Section III affected by the rate of change in the Medical Care appropriation, plus additional programs, listed in subparagraph 3l, that have been moved from Specific Purpose to General Purpose effective for FY 1999. It should be noted that these resources will not be supplemented during the year by Veterans Health Administration (VHA) Headquarters; therefore, VISNs must plan accordingly.

e. The VHA Office of Finance, via the Allocation Resource Center, will distribute additional supportive reports in conjunction with the FY 1999 Network Allocation that will provide details for the allocation process and performance data that could be of assistance in maximizing Network resources.

f. Single Visits funding is allocated at a single national price per veteran user of $100 per patient. Veteran users are defined as all mandatory (category A and X) users that the VISN has seen once over a three year period of time (FY 1995 – FY 1997). For FY 2000, this issue will be revisited and determination made as to what constitutes a fully-visited patient even with one visit. Single Visit data was prepared by the Office of Finance from data developed by the Office of Policy and Planning.

g. Basic Care funding is allocated to each VISN using a single national price per veteran user multiplied by the count of veteran users in each VISN. Veteran users are defined as all mandatory (category A and X) users that the VISN has seen over a 3-year period (FY 1995 - FY 1997). Veteran user data was prepared by the Office of Policy and Planning.

h. Complex Care funding resources will be allocated to each VISN using a single national price per Complex patient user multiplied by the forecasted FY 1999 count of Complex patient users at each VISN. Complex Care patients are defined as the projected number of Complex patients that the VISN will care for in FY 1999 based upon historical demand from FY 1993 through FY 1997. The VHA Office of Finance prepared Complex Care patient forecasts.

i. Each VISN's allocation will be adjusted by a labor adjustment factor that represents its cost of labor relative to the national cost of labor. The labor adjustment will be a zero-sum adjustment at the national level, and is applied to a measure of labor dollars which for FY 1999 is the normal pay for the most recent four pay periods in FY 1998 that are accessible and verifiable to the Allocation Resource Center (ARC).

j. Research support funding for each VISN is also established using a nationally-defined pool of resources and a nationally defined algorithm. Research support resources are those that were reported in the Cost Distribution Report (CDR) in FY 1997. The research algorithm distributes resources using a national rate per Department of Veterans Affairs (VA) and non-VA funded research. VA and non-VA funded research resources were determined by the Office of Research and Development for FY 1997. Starting in FY 1999, the workload allocation factor for the distribution of the Research Support funding has changed from crediting 100 percent of the funded research (VA and non-VA) reported by the Networks, to a method that rewards VA administered Research. This change credits VA-administered research at 100 percent; non-VA funded, non-VA administered, peer review research at 75 percent; and other non-VA funded, non-VA administered, non-peer review research at 25 percent.

k. Education Support funding for each VISN is established using a nationally-defined pool of resources and nationally-defined algorithm. Education Support resources are those that were reported in the CDR in FY 1997. The education algorithm distributes resources using a national rate per resident position. Resident positions are those positions distributed to each VISN by the Office of Academic Affiliations for the academic year 1998-1999.

l. Equipment funding (Object Class 31) is for equipment procured for existing facilities, automated data processing (ADP) requirements, and activation projects. The distribution of FY 1997 and FY 1998 equipment funding was based on clinical complexity data (weighted score of 50 percent), unique patient count by Network (weighted at 25 percent), and Consolidated Memorandum Receipt (CMR) historical purchase rate as a measure of current equipment (weighted at 25 percent). Beginning in FY 1999, the equipment funding is being changed to recognize the need to fund patients, not facilities, and gradually phase equipment funding into the VERA Basic and Complex care elements. The equipment funding algorithm is being revised to use the Basic and Complex workload for each Network as the distribution factor. The equipment funding revision is being phased in over a 2-year period. In each of the next 2 years, FY 1999 and FY 2000, 50 percent of the difference between the equipment funding methodology in FY 1997 and FY 1998 and the revised method in FY 1999, will be used to allocate equipment funds to Networks.

m. Non-recurring Maintenance and Repair (NRM) (Object Class 32) for FY 1997 and FY 1998 was based on a 90 percent Boeckh (square footage) index and 10 percent on the national pricing pool of funding. In FY 1999, the NRM funding is being changed to fund patients, not facilities, and adjust for differences in regional construction costs. This will be accomplished by using the Basic and Complex care workload for each Network, and the portion of the Boeckh Index that adjusts for the cost of construction; phasing this in over 3 years in equal increments, thus adding 33 percent of the difference between the NRM methodology in FY 1997 and FY 1998 and the revised method in FY 1999, 66 percent in FY 2000, and 100 percent in FY 2001.

2. Format of the Network Allocation

a. **Section I.** General Purpose includes Patient Care Resource funds that are composed of Single Visits, Basic and Complex Care; with a labor adjustment; Research, and Education support; a 5 percent cap on losses; and Capital Assets, composed of funding for equipment and NRM projects that will become capitalized assets.

b. **Section II.** Travel is composed of funds for employee travel.

3. Medical Care Program Notes

a. **Full-time Equivalent (FTE) Employment**. In FY 1999, FTE levels will not be assigned during the budget process. Any required accountability and control of supportable FTE will be accomplished at the VISN level. Readjustment Counseling (25), Health Professions Education Programs (26), and other programs with specific FTE are not in the Network Allocation. They will be identified in subsequent funding actions. Networks will not be assigned a personal services floor. Adequate personal services should be budgeted to support planned employment levels.

b. **Funding for Specialized Programs**. Programs such as Post-traumatic Stress Disorder, Substance Abuse, and Homeless Veterans, whose workloads are captured in the VERA model, are included in Section 1 of the Network Allocations. A portion of the allotments provided on the Network Allocation in Section 1 will be made available to these programs. Additional funding adjustments may be accomplished during the fiscal year. Funds received after the Network Allocation, which are allocated for a specific program, must be used for that program or returned to VHA Headquarters program office that provided them.

c. **Medical Care Collections**. In FY 1997, Public Law (Pub. L.) 105-33 established the Medical Care Collections Fund (MCCF). Effective July 1, 1997, Pub. L. 105-65 authorized the transfer of collections in the fund to the Medical Care Appropriation where they remain available until expended. Timing of these transfers and use of the funds are outlined in VHA Directive 98-001, dated January 9, 1998. Each VISN will receive its proportionate share of all MCCF funds. All expenses associated with billings and collections will be charged to the Medical Care appropriation.

d. **Capital Assets**. All funds identified in the FY 1999 Network Allocation for Equipment and NRM are for Object Class 31 and Object Class 32 capitalized assets, as defined in Office of Management and Budget (OMB) Circular No. A-11. As recommended in the Office of the Inspector General (OIG) Report, "Audit VHA Major Medical Equipment Acquisition (Number 5R4-E01-120)" dated September 29, 1995, VISNs will be responsible for informing management at VA medical facilities of the availability of 14-month funds and will develop a schedule detailing the release of funds for equipment acquisition. While the OIG recommendation is equipment-specific, the underlying concept, of encouraging the facilities to take advantage of the 14-month time frame for the planning and purchasing of equipment, applies to both Object Classes 31 and 32.

(1) The allocations for Object Class 31 equipment include funding for equipment procured for existing facilities, ADP requirements, and activations projects. Allocations provided for equipment will include both 1-year and multi-year funds that will be available for 14 months beginning August 1, 1999. The 1-year equipment funds, while identified for equipment in their initial allocation, are not subject to the obligation requirements of the multi-year funds and may be used for expenditures other than Object Class 31.

(2) All allocations provided for the NRM program in the FY 1999 Network Allocation are multi-year Medical Care appropriation Object Class 32 funds that will be available for 14 months beginning August 1, 1999. VISNs must manage leasehold improvements (build out), emergencies, interim projects that arise during the period, and changes or modifications to approved projects and should establish a contingency or "risk pool" for these purposes.

e. **The Health Professions Education Programs (Program 26).** The Health Professions Education Programs (Program 26) include Medical and Dental Residents, Specialized Fellows, Veterans Administration Learning Opportunity Residencies (VALOR) and Associated Health Trainees. The Office of Academic Affiliations will allocate facility specific FTE and funding. If trainee positions cannot be filled, local officials in conjunction with Fiscal Service should notify the Office of Academic Affiliations (144), so resources can be redistributed according to national needs. Trainee positions may not be switched between specialties without prior approval of Academic Affiliations.

f. **The Employee Education Programs (Program 27).** Effective with FY 1999 all Employee Education funds, except funds for operation of the Employee Education System, have been moved into General Purpose and will be distributed by VERA or included in the VISN's travel allocation. This includes travel for both participants and VA faculty at Employee Education System activities, as well as all costs related to Executive Development and Administrative Trainees. Funds for Employee Education System staff, programming, and operations will continue to be funded through Specific Purpose.

g. **Non-VA Workload Programs.** Non-VA workload programs include the State Home (Program 24), Community Nursing Home Care (Program 24), Fee Medical, Fee Dental, and Contract Hospital Programs.

(1) Fee Medical, Fee Dental, Contract Hospital, and Community Nursing Home Care, while funded as part of the model, are still considered non-VA workload programs.

(2) The State Home Program will continue to be funded through Specific Purpose funds and restrictions apply to the funding and workload. If the actual census for any state home category varies from the assigned level the program office should be contacted to make the appropriate adjustments to workload and funding levels.

h. **Employee Travel (Limitation .007)**

(1) Facility Regular. This allocation is provided to cover normal facility-directed employee travel requirements. This includes travel funds for attendance at conferences and both participant and faculty attendance at Employee Education System activities.

(2) All Other. These allocations are provided for specifically identified employee travel, such as Readjustment Counseling.

i. **Prosthetics.** VHA Headquarters-allocated funds for the repair and purchase of prosthetic appliances will be provided as Specific Purpose funding. General Purpose funds will be used to supplement prosthetics when Specific Purpose funds are insufficient. Funding for Automatic Implantable Cardiovascular Defibrillators (AICD) has been decentralized and is part of the General Purpose funds distributed by VERA. Prosthetic activities will continue to be monitored by the Prosthetics and Sensory Aids Service (117C) at the individual facility and/or VISN levels.

j. **Leases.** In FY 1999 only the "Mega Leases" for Anchorage, Columbus, Honolulu, Las Vegas, Manila, the Northern California System of Clinics, and field-based national programs will be supported by VHA Headquarters. All other lease expenses, including leasehold improvements (build-outs), will be supported at the VISN level.

k. **Items not Included in Network Allocation**. Allocations included in Sections I through II reflect the FY 1999 allocation for all Medical Care requirements except the following:

(1) Allocations for Reimbursable Costs collected by VA Facilities. As indicated in the Office of Management and Budget (OMB) Circular A-34, funds must be collected from non-Federal sources during the fiscal year the receivable is established to receive credit for reimbursement. This has been modified by Public Law (Pub. L.) 104-262 which says: collections for the sharing of medical resources, Title 38 United States Code 8153 and TRICARE intermediaries are budgetary resources in the year they are collected, regardless of when the service was performed. Facilities will receive funding on a monthly basis in arrears for those actual earned and/or collected reimbursable costs recorded in the Financial Management System (FMS) Standard General Ledger accounts 425F (Federal Receivable-Reimbursements), 425G (Federal Collections- Reimbursements), and 425P (Non-Federal Collections-Reimbursements). Reports Control Symbol (RCS) 10-0027, the Quarterly Report of Need/Excesses, was discontinued in FY 1998.

(2) Permanent Change of Station (PCS). In FY 1997, permanent change of station funding was decentralized to the field and is included in the Network Allocation. The only VHA Headquarters funding for PCS that will be provided is for senior management of field based national programs and resident engineers. All other PCS expenses for field-based national programs will be absorbed within the funds available to the program activity. Funds will be provided in accordance with VA and Federal Travel Regulations. Requests for funding will include the program name, incumbent's name, position being filled, reporting date, and itemized costs for salary, all other, and travel.

l. **New Items Included in the Network Allocation**.

(1) Effective in FY 1999, the following items, previously funded by Specific Purpose are included in the General Purpose funds provided in the Network Allocation.

(a) Recruitment and Retention Tuition,

(b) Substance Abuse (Alcohol and Drug Halfway House),

(c) College of American Pathologists, and

(d) Administrative Trainees.

(2) Franchise Fund Activities as indicated in the following:

(a) VA Records and Vault Storage, i.e., Neosho, MO.

(b) Security Office, i.e., background investigations.

(c) Law Enforcement Training Center, i.e., in-service training.

(d) Law Enforcement Training Center, i.e., Resident Training.

(e) Austin Automation Center, i.e., time share access.

(f) Austin Automation Center, i.e., Consolidated Co-payment Processing for 1st party collections.

(g) Austin Automation Center, i.e., lockbox for 1st party debt remittance.

(h)Austin Finance Center, i.e., Payroll and Accounting.

(3) Medical Care Cost Recovery as indicated by the following:

(a) Area Directors;

(b) Ft. Meade and Ellsworth;

(c) Multi-media development;

(d) Communications service, i.e., IDCU; and

(e) Digital Equipment Corporation (DEC), i.e., Veterans Health Integrated Systems Technology Architecture (VISTA) Hardware Maintenance Contract.

ATTACHMENT B

FY 1999 NETWORK ALLOCATION GLOSSARY OF TERMS

1. **Administrative Subdivision of Funds.** An administrative subdivision of funds is any subdivision of an appropriation or fund, subject to the provisions of the Antideficiency Act, which makes funds available in a specified amount for the purpose of incurring obligations. Under the Department of Veterans Affairs (VA) administrative control of funds only allotments are considered to be administrative subdivisions of funds. An example of an administrative subdivision of funds (allotment) is the breakout of funds by activity (department or staff office) within the General Operating Expenses Appropriation. (Source: MP-4, Part V, 1B.04.a)

2. **Allocation.** This term is used in two different ways:

a. It is used restrictively to mean the amount of obligational authority transferred from one agency, bureau, or account that is set aside in a transfer appropriation account (also known as an allocation account) to carry out the purposes of the parent appropriation or fund.

b. It is used broadly to include any subdivision below the suballotment level, such as subdivisions made by the agency financial plans or program operating plans, or other agency restrictions. (Source: Office of Management and Budget (OMB) Circular No. A-34, Sec. No. 11.4)

3. **Allotment.** Authority delegated by the head or other authorized employee of an agency to agency employees to incur obligations within a specified amount, pursuant to OMB apportionment or reapportionment action or other statutory authority making funds available for obligation. (Source: OMB Circular No. A-34, Sec. No. 11.4)

It is an authorization by the Deputy Assistant Secretary for Budget to agency heads and staff office directors to incur obligations within specified amounts, during a specified period, pursuant to OMB apportionment or reapportionment action or other statutory authority making funds available for obligation. An allotment is an administrative subdivision of funds and therefore is subject to the provisions of the Antideficiency Act. (MP-4, Part V, Chapter 1, Paragraph 1B.043)

4. **Apportionment.** An apportionment is a distribution made by OMB of amounts available for obligation in an appropriation or fund account into amounts available for specified time periods, programs, activities, projects, objects, or combinations thereof. The apportioned amount limits the obligations that may be incurred. (Source: OMB Circular No. A-34, Sec No. 11.4)

5. **Appropriation.** Authority given to federal agencies to incur obligations and to make payments from the Treasury for specified purposes. An appropriation act, the most common means of providing budget authority, usually follows the enactment of authorizing legislation, but in some cases the authorizing legislation itself provides the budget authority. (Source: General Accounting Office (GAO) AFMD-2.1.1Budget Glossary)

6. **Allowance.** An authorization by department (heads) and staff office (directors) to facility Directors and other officials, of obligational authority, showing the expenditure pattern or operating budget they will be expected to follow in the light of the programs and activities contemplated by the overall VA budget or plan of expenditures. (Source: MP-4, Part V, 1B.04.d)

7. **Fee Basis.** A type of contractual arrangement on an individual basis, for an individual situation, for a designated period of time, and authorized via a VA Form 10-7079 or a VA Form 10-1174, Fee Basis ID Card,. This responsibility has traditionally been that of Medical Administration Services (MAS) at most facilities. Due to mergers, reorganizations and restructuring many MAS activities have ceased to exist and responsibility for program shifted to other areas of facilities. Would use Budget Object Class (BOC) 2562 or 2570. (Source: Health Administration Service)

Non-VA physician is brought into a Veterans Health Administration (VHA) facility to treat a veteran patient. Would use BOC 2561 or 2571.

8. **General Purpose Funds.** Allocated funds based on a methodology using quantifiable workload measures. These funds are provided to the networks at the beginning of the fiscal year, generally, without restrictions on how they can be spent. Example of exception is multi-year funds restricted to equipment and lands and structures. (Source: Glossary to Table B1 for Fiscal Year (FY) 2000)

9. **Patient Treated.** This term is used in two different ways:

a. In the traditional sense and used in computing a measure of work – total discharges plus patients remaining bed status plus patients remaining non-bed status.

b. More recently used to mean treatment of a specific veteran which is also referred to as a unique or unique social security number (SSN).

10. **Prorated Person (PRP).** Computation based on share of a patient's national cost. At the national level, each SSN for whom we have provided care counts as one PRP. Each Veterans Integrated Services Network (VISN) providing care for the individual is assigned a proportion of the PRP in relation to the their share of the costs of care for the individual. (Source: Allocation Resource Center Web Site)

11. **Refund.** Repayment of excess payments. The amount is directly related to previous obligations incurred and outlays made against the appropriation. Refunds are to be deposited to the credit of the appropriation or fund account charged with the original obligation and treated in the following manner.

a. Refunds collected by unexpired annual and multi-year appropriations and uncanceled no-year appropriations.

b. Refunds collected by expired annual and multi-year appropriations are available for

upward adjustments of valid obligations incurred during the unexpired period but not recorded.

c. Refunds to canceled annual, multi-year or no-year appropriations are required to be deposited in miscellaneous receipts in the Treasury.
(Source: OMB Circular No. A-34, Sec No. 11.2)

12. **Reimbursement.** Collection that is received by the federal government as a repayment for commodities sold or services furnished either to the public or to another government account and that is authorized by law to be credited directly to specific appropriations and fund accounts. (Source: GAO/AFMD-2.1.1Budget Glossary)

13. **Specific Purpose.** Allocated funds distributed to the networks or medical facilities over the course of the fiscal year for specific events and activities. The funded levels are determined by the need of the specific event or activity. (Source: Glossary to Table B1 for FY 2000)

14. **Unique Patient.** An individual patient who can be identified by the presence of a singularly unique SSN. (Source: Allocation Resource Center Web Site)